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CHANGING DIETARY AND HEALTH PRACTICES

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CHANGING DIETARY AND HEALTH PRACTICES by

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SUMMARY

1. Health and dietary habits are devices by which a population adapts to its habitat. The process called "development" refers to a double change: the population accelerates the exploitation of the habitat such that the habitat changes. Within the society there is an increase in complexity such that new social groups and segments emerge, thereby providing each segment with a new social habitat. Development demands a constant readaptation of the population, both socially and environmentally. The new groups, because of their specific activities and contacts, develop new disease syndromes peculiar to themselves. A consequence of the acceleration of exploitation of the habitat is the more rapid utilization and expenditure of the products. This means that new foods and new food processing is developed. The same occurs in sanitary technology and medical therapy, where increasing quantities and varieties of materials are utilized to achieve hygienic conditions.

2. The attempt to introduce new practices, however, faces two conditions: one is the presence of knowledge in the society; the other is the nature of the socio-psychology of innovation and acceptance. In all societies we can distinguish the knowledge of the non-specialist, that is the "folk knowledge" from that of the specialist. It makes no difference how developed a society is, the great majority of the people have a folk knowledge of health. Practices, learned from seniors and peers, are carried out both because they are socially reliable and because there is some evidence of efficacy. More developed societies have a folk knowledge that has more elements, changes more rapidly, and is more subject to fads. Changing folk knowledge faces essentially the same problem in all societies. When alternatives are clear to people, they will make rational choices in terms of their understanding and values. When choices are ambiguous, and a choice must be made, they will look to a reference group as a guide. Thus social approval will often supplant medical logic. Much more often than not, the apparent "irrationality" of people refusing to accept innovations is due to the ambiguity of the alternatives. This means that health-action workers must learn better how and what to communicate into other social groups.

3. The actual application of health programs has often been done on the means-ends model. That is, a given set of conditions is desired, and steps are taken to achieve these goals. While this may work in cases where the goal is modification of the environment (as is the case in environmental sanitation and in the eradication of certain diseases), it cannot be expected to work well where changing habits is the crucial issue. Here it is necessary to model projects after evolutionary processes, and see the acceptance of new traits as a continuing readaptive process of the population. Analysis of innovation failures must be fed back and help modify innovation attempts. This process, recently called "research and development", has a long history. It was the basis for the success of the Land Grant College system that has made the United States the leader in world agriculture. As a principle, it must be applied to the design of health programs if they are to help the people of the world readapt to the constantly changing environment.

